

H&R BLOCK

Return the completed form to:
Benefits Department
H&R Block
4400 Blue Parkway
Kansas City, MO 64130

REQUEST FOR LEAVE OF ABSENCE

Instructions: Sections 1, 2, 3 and 4 are to be completed by the associate. Check all applicable boxes and sign and date Section 6. Return the completed form to the supervisor. The supervisor signs and completes Section 6 and returns the form to the H&R Block Benefits Department at the address above.

Section 1

Associate's Name:	Dre McCray	Social Security Number:	_____
Job Title:	Field HR Manager	Corporation:	_____
Department:	Field HR		
Is your spouse employed by H&R Block corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable			
If yes, spouse's name and corporation where employed? _____			
Last Day Worked:	11-18-02		
I request leave: From	11-19-02	to	12-2-02
Initial request:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If no, is this a request for extension or additional time off: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2

Identify the reason for the leave (check the applicable box):

Medical (self) Family Related Maternity Military Personal

Section 3

The requested leave is for (check any applicable boxes):

- The birth of a child and/or care for a child within the 12-month period following birth.
- The adoption or foster care placement of a child and/or to care for a child within the 12-month period following adoption or placement.
- To care for my spouse, son, daughter or parent with a serious health condition. I understand that a completed "Certification of Health Care Provider" form is required.
- Because of a serious health condition (non-job related) that prevents me from performing the functions of my job. I understand that a completed "Certification of Health Care Provider" form is required.
- Because of a serious health condition due to occupation. I understand that a completed "Certification of Health Care Provider" form and an "Employee Accident, Injury or Illness Report", Form 2414 are required.
- Other - Please explain: _____

DEC 04 2002 NS

Nov. 27 2002 23:56PM F1

DM : Section 4

I request that my leave be taken:

- Consecutively (consecutive leave is taken successively in an uninterrupted order)
- On an intermittent basis as follows: (Intermittent leave means that the entire leave is not taken consecutively but is taken in smaller increments such as days or weeks.) AS NEEDED
- On a reduced work schedule basis as follows: (Reduced leave means a reduction in the usual number of hours worked per work week or work day.) AS NEEDED

Section 5

An employee is eligible for leave under the FAMILY AND MEDICAL LEAVE ACT (FMLA) if the employee has been employed by the employer for at least twelve months and the employee has been employed for at least 1,250 hours during the immediately preceding twelve month period. An eligible associate who is approved for FMLA based on medical certification may take up to a total of twelve (12) work weeks of unpaid FMLA leave during a twelve (12) month period (or longer if required by applicable state or local law). The twelve (12) month period is determined using a rolling twelve (12) month period measured backward from the date the associate begins using any FMLA leave.

If eligible, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above in Section 3. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or 2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Section 6Associate's Signature Adrian McCrayPrint Name ADRIAN McCRAYDate 11/24/02

Department Manager's Signature

Print Name

Date

HR Manager/Representative Name: Dre McCray

Required Please Print

Region Number 10

Check the Applicable Box Below (to be completed by Department Manager):

 Recommend Approval of Leave Do Not Recommend Approval of Leave

Reason: Pending receipt of Certificate of Health Care Provider - Carol Etchae, Director Field HR 12/4/02